California Office of Suicide Prevention eNEWS

Every Californian is Part of the Solution... *How will you contribute?*

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SUICIDE PREVENTION IN PRIMARY CARE SETTINGS

Over 30,000 individuals die by suicide every year nationwide. Despite common beliefs, many individuals who die by suicide are not connected to mental health services. In fact, studies have shown that a substantial number of individuals see their primary care physicians (PCP) in the weeks and months leading up to their suicide. **Reaching out and educating PCPs and their staff in suicide prevention, intervention, treatment and referral is essential to help reduce suicides across California.**

DO YOU RECEIVE THE eNEWS?

If so, the Office of Suicide Prevention is interested in hearing from you! The Office wants to tailor the eNews to best suit your needs. Please take a few minutes to answer this confidential survey. If you have any questions, please contact The Office of Suicide Prevention.

WHAT WE KNOW ABOUT SUICIDAL IDEATION IN THE PRIMARY CARE SETTING

Individuals experiencing suicidal thoughts do not always seek psychiatric assistance from mental health professionals. For many reasons, which can include issues of stigma or lack of access to mental health care services, many individuals may seek help from their primary care physician (PCP). In one study, only 19% of individuals who died by suicide went to see a mental health professional in the month leading up to their death, while 45% went to see a PCP in that time period. In addition, a large majority of these individuals seeking services from primary care settings were older adults (Luoma, et al., 2002). This is important, as older adults have the highest rates of suicide among any age group in the country.

Despite the high percentage of individuals seeking services from primary care settings, PCPs are often not trained in suicide prevention and treatment. As a result, there are missed opportunities to identify and respond to suicide risk. (Mann, et al., 2005).

Individuals experiencing emotional or psychiatric distress may not be forthcoming with concerns about their mental health. If PCPs are able to identify the warning signs for suicide risk and take the time to understand their client's emotional state, action can be taken that may help prevent a suicide. PCP actions may have significant impact for the patient and link them to needed resources.

RISK FACTORS PCPS SHOULD BE AWARE OF

A number of different factors can elevate an individual's risk of suicide. Below are just some examples (Gillmore & Chan, 2004).

Past Behavior: The best predictor of suicide is past suicide attempts. However, indications that an individual is "accident prone" or exhibits "impulsive behavior" may also be a warning sign.

Psychiatric Illness: 90% of individuals who die by suicide had a diagnosable mental health or substance abuse disorder. Mood disorders, such as major depression or bipolar disorder, are particularly prevalent. Substance use also indicates elevated risk; about 20% of suicides happen while the individual is intoxicated.

Medical Illness: According to Gillmore & Chan, more people with HIV/AIDS die by suicide than any other medical illness. Other illnesses that are frequently associated with suicide include neurologically-based illnesses, pulmonary disease, cirrhosis, and peptic ulcers. Cancer and asthma have also been shown to increase the odds of a suicide attempt (Druss & Pincus, 2000)

New Behaviors: Giving away personal items, an increasing level of alcohol consumption, or stock-piling medications may indicate potential suicidal plans.

CONDUCTING A MENTAL HEALTH ASSESSMENT

If a clinician suspects that a client is experiencing emotional distress, a mental health assessment should be conducted. **Asking questions about risk does not cause an individual to contemplate suicide. In fact, individuals at risk for suicide often feel relieved to talk about it** (Gillmore & Chan, 2004). According to the Suicide Prevention Resource Center (SPRC), there are no explicit guidelines for determining a patient's risk of suicide. The following questions can help start a conversation to better understand a client's current state of mind and their intentions:

- Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts?
- Are you thinking about killing yourself?

Screening for suicidal ideation can result in four possible clinical outcomes: 1) no desire to die or thoughts of deaths; 2) death wishes but no thoughts of harming self; 3) suicidal ideations without a plan; or 4) suicidal ideations with a plan. In general, clients who fall into outcomes 1 and 2 can be managed in primary care. Otherwise, clients who express suicidal ideations with or without plans should be referred to mental health specialists for further assessment, treatment and monitoring (McCarron, et al., 2009).

WHAT CALIFORNIA IS DOING TO HELP

The California Strategic Plan on Suicide Prevention, Strategic Direction 2 states that expert workgroups should be convened to recommend, develop, disseminate, promote, and evaluate suicide prevention service and training guidelines, as well as model curricula for targeted occupations, including primary care providers.

Through the Mental Health Services Act, UC Davis has developed a replicable and integrative residency training program called IMPART (Integrated Medicine/Psychiatry Ambulatory Residency Training) Program. IMPART is only one of two programs in the country to have both family medicine/psychiatry and internal medicine/psychiatry residency programs.

RESOURCES & TOOLKITS

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) is a multi-faceted primary care intervention that has demonstrated reductions in suicidal ideation and depression in older adults. It is available through Weill Medical College of Cornell University.

Toolkit for Rural Primary Care Providers was created in partnership between The Western Interstate Commission for Higher Education and SPRC. It includes best practices for suicide prevention, tools for improving detection and intervention skills, guidelines for developing office protocols for crisis situations and resources for community-based outreach.

IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) is an intervention for older adults with depression or dysthymic disorder. It uses a collaborative care approach in which a nurse, social worker, or psychologist works with a primary care provider, a depression care manager and the patient to develop a course of treatment.

American Association of Suicidology (AAS): Recognizing and Responding to Suicide Risk in Primary Care is a one-hour training that provides primary care staff with the knowledge they need to integrate suicide risk assessments into routine office visits, formulate relative risk and work with patients to create treatment plans.

LOCAL ACHIEVEMENTS

Humboldt County is forming an older adult suicide prevention workgroup that will focus on suicide prevention training and outreach in primary care settings. For more information, please contact Kris Huschle at khuschle@co.humboldt.ca.us.

Marin County is implementing three programs aimed at integrating mental and physical health care. The projects include the Integrated Marin Community Clinic, placing mental health providers in local community clinics, and implementing the IMPACT Project locally.

LEARN MORE ABOUT SUICIDE PREVENTION IN PRIMARY CARE SETTINGS

Suicide Prevention Resource Center (2005). Primary Care Physicians. ***Newton, MA: Education Development Center, Inc.***

This paper provides an overview of the role that PCPs play in preventing suicide, and guidelines for recognizing and acting upon the warning signs.

Substance Abuse and Mental Health Services Administration (2008). Compendium of Primary Care and Mental Health Integration Activities across Various Participating Federal Agencies.

Integrated care results in improved access to care, and improved patient well-being. This report highlights a variety of federally-funded integration activities for many different high-risk populations.

McCarron RM, Xiong GL, Bourgeois JA (2009). Lippencott's Primary Care Psychiatry. ***Philadelphia, Pennsylvania: Wolters Kluwers.***

This book contains chapters with easy-to-follow diagnostic and treatment algorithms, clinical highlights, case examples and indications for psychiatric referral.

Bryan CJ, Rudd DM (2010). Managing Suicide Risk in Primary Care. ***New York, New York: Springer Publishing Company.***

This book discusses the clinical realities for behavioral health consultants (BHC) working in primary care settings. It offers effective strategies for BHCs to manage patients across a suicidal crisis including the development of crisis procedures, steps to take during and after a crisis, transition to specialty mental health facilities and other issues.

OTHER REFERENCES USED IN DEVELOPING eNEWS

Luoma JB, Martin CE, Pearson JL (2002). Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. ***American Journal of Psychiatry. 159: 909-916***

Gillmore JM, Chan CH (2004). Suicide: A Focus on Primary Care. ***Wisconsin Medical Journal: 103(6): 88-92***

Mann JJ, et al., (2005). Suicide Prevention Strategies: A Systematic Review. ***JAMA. 294(16): 2064-2074***

Druss B, Pincus H (2000). Suicidal Ideation and Suicide Attempts in General Medical Illnesses. ***Archives of Internal Medicine. 160: 1522-1526***

ANNOUNCEMENTS & BREAKING NEWS

Asian American and Pacific Islander (AA/PI) Mental Health Listening Session Proceedings.

The National Alliance on Mental Illness (NAMI) hosted the AA/PI Mental Health Listening Session during November 2010 in Los Angeles. This document outlines the discussions, which include the diverse experiences of the AA/PI community when dealing with mental health issues, and barriers and gaps AA/PI individuals and families faced when accessing services. The report also offers recommendations to help mental health systems address these barriers.

The Substance Abuse and Mental Health Administration (SAMHSA) releases "Leading Change: A Plan for SAMHSA's Roles and Actions, 2011-2014".

SAMHSA introduced eight new Strategic Initiatives that will guide its work from 2011 through 2014. These initiatives help people with mental and substance use disorders and their families build strong communities, prevent behavioral health problems, and promote better health for all Americans.

RECENT RESEARCH FINDINGS

Vannoy SD, et al. (2010). Suicide Inquiry in Primary Care: Creating Context, Inquiring and Following Up. ***Annals of Family Medicine. 8(1): 33-39***

This article describes the vocabulary and narrative context of primary care physicians' inquiries about suicide. It found that although most inquiries were clear and supportive, some may have unintentionally reinforced patients to remain silent about their risk.

Vargehese P & Gray BP (2011). Assessment of Adolescents in the Primary Care Setting. ***The Journal for Nurse Practitioners. 7(3): 186-192***

The purpose of this article is to update evidence-based best practices for pediatric primary care providers related to suicide assessments, including prevalence, risk factors, risk assessment, screening tools, management and preventive strategies.